Systematic Case Review

Objectives

- Review of the process of SCR
- Identify key components of follow up and monitoring (Treat-to-Target/Treatment Intensification
- Identify the process of tracking patient progress - tracking

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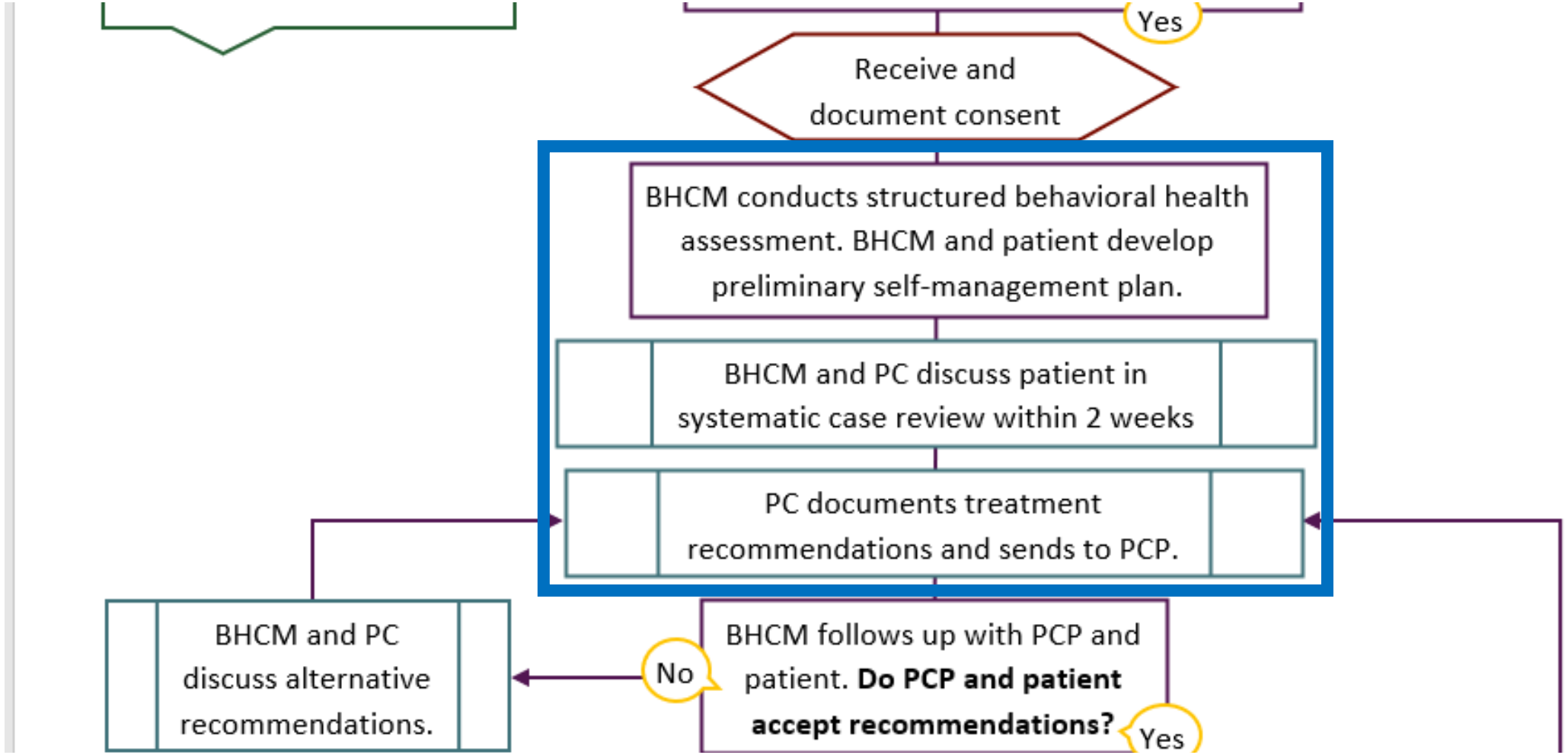
Systematic Case Review



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The Value of the Systematic Case Review Tool

- Population health – making sure patients are not falling through the cracks
- Caseload management at-a-glance
- Track treatment engagement & response
- Prioritize patients who are not responding or disengaged
- Track patients' symptoms with measurement tools (PHQ-9, GAD-7)
- Track medication side effects & concerns
- Facilitate caseload review with Psychiatric Consultant

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Systematic Case Review Tool

Patient Information		Contact Information					Depression Outcomes					Anxiety Outcomes				Psychiatric Panel Review Information			
Name	Treatment Status	Date of Initial Contact	Date of Most Recent Contact	Number of Patient Contacts Completed	Weeks in Treatment	Date Next Contact Due	Initial PHQ-9	Most Recent PHQ-9	Difference in Most Recent PHQ-9	Most Recent PHQ-9 #9	Date of Most Recent PHQ-9	Initial GAD-7	Most Recent GAD-7	Difference in Most Recent GAD-7	Date of Most Recent GAD-7	Date of Most Recent Panel Review	Flag to Discuss	Patients Not Improving at 8 Wks	Outstanding Psych Recs
Lion, Leo	Active	12/17/18	3/29/19	3	19	4/28/19	21	21	0	0	3/29/19	21	21	0	3/29/19	4/5/19			
Doe, Jane	Active	4/12/19	4/22/19	3	2	4/29/19	17			0	4/12/19	19			4/12/19	4/19/19	Flag to Discuss		
Green, Sky	Active	12/24/18	4/17/19	6	18	5/1/19	17	5	-5	0	4/17/19	18	✓ 4	-6	4/17/19	4/17/19			
Smith, John	Active	2/28/19	4/17/19	2	9	5/1/19	7	8	1	0	4/17/19	21	12	-9	4/17/19	4/19/19		Attn Needed	
Blue, Jeans	Active	4/23/19	4/23/19	1	1	5/7/19	16			0	4/23/19	19			4/23/19	4/26/19	Flag to Discuss		Pending
Yellow, Joy	Active	12/31/18	4/11/19	7	17	5/11/19	19	11	0	0	4/11/19	17	21	0	4/11/19	4/12/19			Pending
Jupiter, Mars	Active	12/17/18	4/29/19	10	19	5/13/19	18	✓ 3	-7	0	4/29/19	21	8	5	4/29/19	4/12/19			
Shine, Sun	Active	4/29/19	4/29/19	1	0	5/13/19	22			0	4/29/19	21			4/29/19		Flag to Discuss		
Michigan, Cherry	Active	10/22/18	4/30/19	13	27	5/14/19	18	21	0	0	4/30/19	20	21	0	4/30/19	4/12/19			
Smile, Big	Active	11/13/18	4/30/19	8	24	5/30/19	20	11	-7	0	4/25/19	17	10	-7	4/25/19	4/26/19			

Note: This example includes many “nice to have” components; more simplified tools will suffice.

SCR Tool: Required Elements

- Patient identification
- Treatment status (e.g., active, inactive, relapse prevention)
- Date of enrollment and disenrollment
- Baseline and follow-up outcome measure scores (PHQ-9 and/or GAD-7) and dates
- Date of BHCM follow-up contacts with patient

** See the BCBSM CoCM Designation Program Criteria for future requirements (1.4)

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SCR Recommended Elements

Overall change in PHQ-9 and/or GAD-7 scores

Most recent change in PHQ-9 and/or GAD-7 scores (i.e., difference in two most recent scores)

BHCM contact frequency (e.g., one-week, one month) or next contact date

Date of most recent panel review session (SCR date)

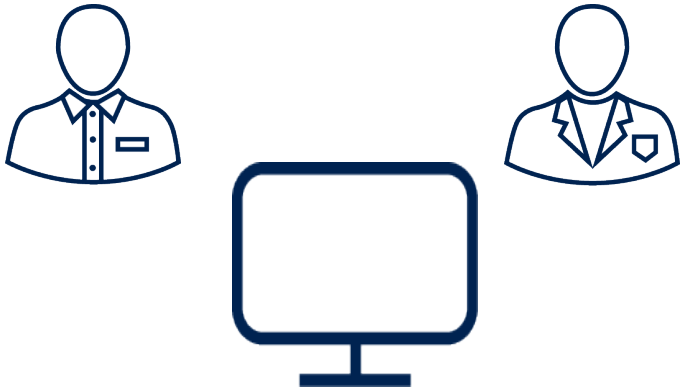
Outstanding psychiatric treatment recommendations

Flags to discuss in panel review

1. Visualize patients whose condition is improving or worsening; and
2. Indicate patients who would benefit from contact, updated outcome measures, or panel review session

When - How Often - Where

- Half-time BHCM: Typically, one hour per week
- Additional time available for curbside consults and questions
- In-person or via HIPAA-compliant videoconference



- **Systematic case review should be scheduled on a weekly basis and should not be done ad hoc**

Leveraging Psychiatry Time

Goal: Determining patients per hour

- Succinct and thorough
- With experience you'll build efficiencies

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SCR Best Practices: Formatting

1. Brief check-in
2. Urgent patients
3. Specific case questions
4. New patients
5. Patients due for review to meet monthly requirement
6. Review the patient panel – run the list
    I. Worsening or not improving
    II. Scores in the severe range
    III. Positive score on question 9 on GAD 7
    IV. Not recently discussed
    V. Not engaging in care
    VI. Been in program for a long time
    VII. In remission and/or ready for relapse prevention

Urgent patients may require contact with the Psychiatric Consultant outside of systematic case review

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Reporting Tool for BCBSM

					Plan Type													Optional			
	First Name	Last Name	Birthdate	Gender	DUMMY IDENTIFIER	Comm PPO	MAPPO	BCN	BCNA	Other	NON-BCBS	Date of Referral to CoCM (DD/MM/YY)	Enrollment in CoCM (Y/N)**	If No, Reason (Refusal, No Response, Other)	Baseline PHQ9 Score (0-27)	Date of Baseline PHQ-9 Score (DD/MM/YY)	Most Recent PHQ 9 Score (0-27)	Date of Most Recent PHQ-9 Score (DD/MM/YY)	Baseline GAD-7 Score (0-21)	Date of Baseline GAD-7 Score (DD/MM/YY)	Most Recent GAD-7 Score (0-21)	Date of Most Recent GAD-7 Score (DD/MM/YY)
Blue Cross patients																					
Non-Blue Cross patients																					

** If response is no, please complete the reason column, but there is no need to fill out the PHQ-9/GAD-7 scores

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Preparing

Step 1: Actions to Prepare for SCR

- Attempt to outreach to all those due
- Be prepared to discuss Information and impact on the treatment from the patient and the provider
- Secure and be prepared with the starting and trending values to include the date(s) completed
- Prepare the SBAR – to include the BHCM'ers recommendations

Step 2: Documents

- Send in advance documents to the psychiatrist (using HIPPA and agreed form(s)
- Send list of all patients due for discussion – consider using the SCR tool list with highlights
- Scribe organizes and prepares to manage SCR (largely the scribe is in the background to allow focus on the clinical progression)
  - Role of the scribe (announce, pull up tool, fill in information as reviewed, timekeeper)

During SCR

Step 3: Announce the number of cases for review

- X number of initial
- X number of follow up
- Add-in's (crisis, admissions/ED, overdue, etc..)

Step 4: Starting reviews using SBAR

- Scribe or assigned person pulls up SCR tool
- Begin review
  - S = patient identifier, start date and result (PHQ and GAD), current date and result, treatment decision,
  - B= patient response to treatment interventions (ie medication, BA, PST, MI), any new information, information **pertinent** to the situation (such as social, medical, behavioral, other services)
  - A=what is going on as it relates to the treatment response (trend)
  - R=When to review to again, what BI's, next contact with the patient, review of relapse prevention planning, and monitoring the results)
    - Confirm using teach back/repeat back document the psychiatrist advice on the treatment plan

SBAR Activity: Preparing for SCR

You've met with Jasmine and completed an assessment and the initial self-management action plan. You are preparing to review Jasmine's case with the psychiatrist. In your assessment you discovered the following:

Jasmine has a PHQ of 15, passive suicidal thoughts.

She has a history of depression as a teenager when her parents were divorced. Saw the school counselor she thinks 3 or 4 times.

Her primary care doctor prescribed Celexa 10 mg daily, 3 years ago– she didn't think it helped much and stopped it on here own. She had no interested in trying medication again.

She has a history of seizure disorders and takes Dilantin for this.

She smokes occasionally about ½ pack a day. Occasionally, socially drinks alcohol.

Regarding sleeping, Jasmine wakes up in the night and has difficulty going back to sleep.

She enjoyed going to the gym and participating in a biking club. She hasn't done either in several months.

She lives with her long-term friend. She doesn't feel he is very supportive. She's not sure where the relationship is going.

She has a teenager son who lives with the father.

She was born and raised in Lansing, her parents fought often before divorcing. She is the oldest of 3, she has 2 younger brothers.

Thyroid studies from 2 years ago were normal.

Follow UP

Step 5: Review recommendations with the patient's provider

- Using the psychiatrist documentation or the BHCM'ers documentation of the psychiatrist recommendations review with the provider
- Set time aside to share psychiatrist recommendations and rationale
- Provider decision follow through
  - Coordinating arrangements (ie prescribing, outreach with service provider, labs, etc.)

Step 6: Review treatment decision with the patient

- Complete the already set up visit (in person or calls) with the patient
- If 2 weeks or more since last done – repeat the PHQ and GAD 7 (if applicable)
- Review the treatment recommendations and rationale
- Using MI skills elicit the patient's thoughts and ideas on the recommendations
- Secure the patient's decision
- Pending on the patient's response, use BA, PST, MI to coach, mentor and support progression
- Schedule next follow up visit
- Update SCR tool

Follow Up

Step 7: Review of patient input

- Share the patient input with the provider. If needed suggestions for treatment plan modifications
- Share the final treatment plan decision at the next SCR
- Scribe reviews updated tool and outreaches to the BHCM with any gaps, missing information, questions

Systematic Case Review Sample Notes

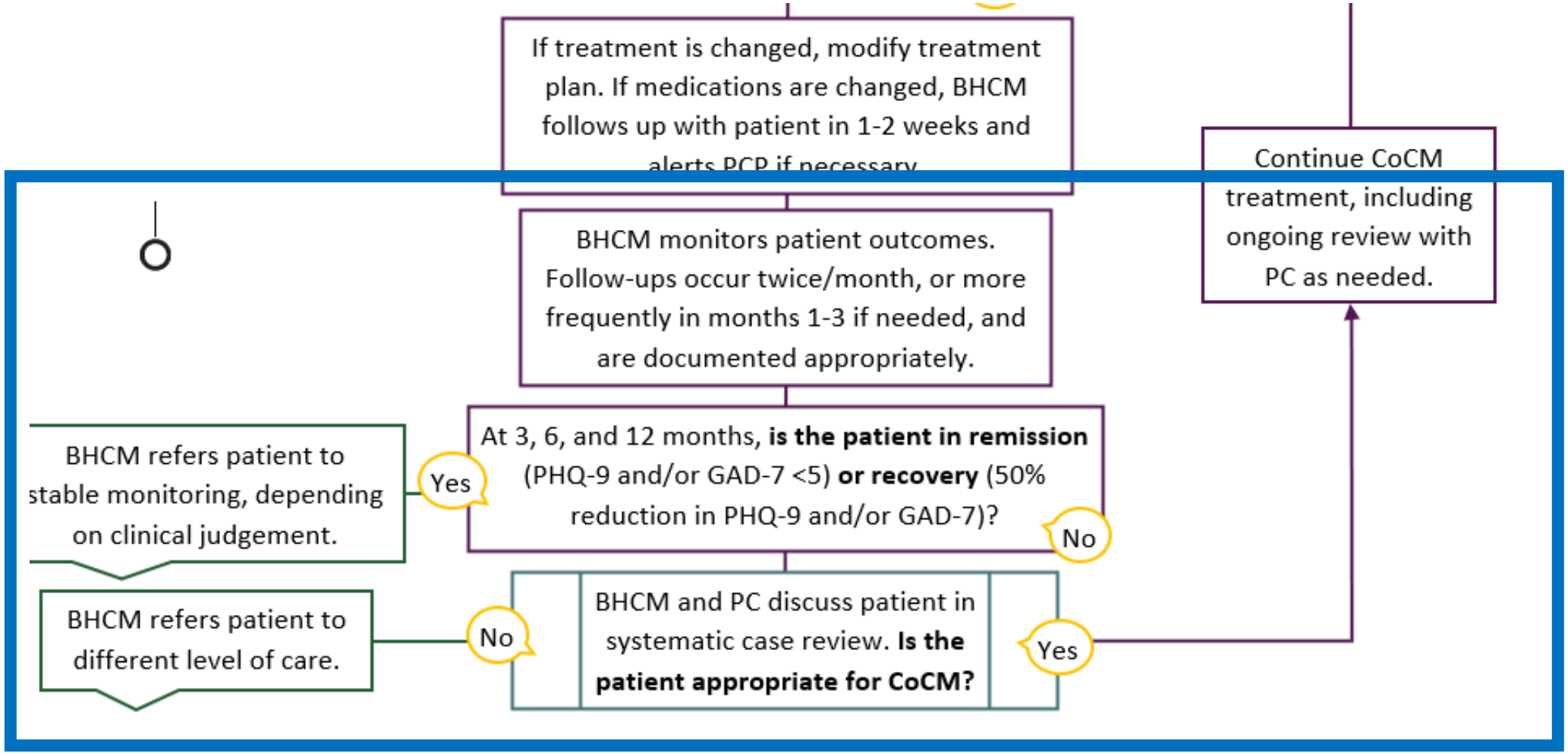
Initial Care Manager Note

Initial Psychiatrist Note

Follow up Care Manager Note

Follow up Psychiatrist Note

Monitoring and Follow Up



Monitoring and Follow-up by Roles

CoCM is a Team-based Approach to managing behavioral conditions using an inter-disciplinary approach

- PCP – Continue to prescribe medications, make medication adjustments as needed, implement treatment recommendations
- BHCM – Provide brief behavioral interventions, monitor symptoms (using the PHQ-9/GAD-7), update registry, talk with patients about medications, consult with PCP and Psychiatric Consultant. **Key actions are identifying progression with treat-to-target and need for treatment intensification.**
- Psychiatric Consultant – Reviews patients with BHCM, prioritizing new patients, those who are not improving as expected, provide treatment recommendations to Care Team
- Patient – Engage with care team and review challenges and successes with the treatment plan
- Determining when the patient is ready for return to usual care

Continuous Activities of the BHCM

- Monitors symptoms and outcomes on a regular basis and tailors the treatment plan in response to symptom acuity and progress toward goals
- Provides psychoeducation to patients surrounding behavioral health issues in both verbal and written formats
- Routinely engages patients in psychotropic medication monitoring and management, providing education and monitoring for side effects and adherence, as well as supporting patients in improving adherence
- Regularly utilizes brief, evidence-based interventions; frequent use of Motivational Interviewing, Behavioral Activation, and Problem-Solving Treatment
- Routinely performs risk assessments and engages patients in safety planning as needed (PHQ9 – positive to question 9)
- Provides appropriate community and supportive resources to patients, acting as a liaison
- Builds the relapse prevention plan and reviews with the patient regularly

BHCM Actions: Follow-up Visit(s)

Use agenda setting to frame the visit (Include the patient's greatest concerns)

Repeat PHQ9/GAD 7 to determine progress with treat-to-target (no more than every 2 weeks)

Address any urgent emergent issues

Follow up on the self-management action plan

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Frequency of Contact

Guidelines:

- Active Treatment – until patient significantly improved/stable – minimum 2 contacts per month; can occur remotely
- Monitoring – 1 contact per month
- After 50% decrease in PHQ-9 • monitor for ~3 months to ensure patient stable • complete relapse prevention planning
- Frequency of outreach will depend on patient's treatments plan, their level of engagement, and if any crisis intervention is needed

Concluding the Visit

- Wrap up the visit
  - Summarize the content
  - Review with the patient the action steps and address any questions
  - Establish the date and agenda of the next visit

BHCM Initial Outreach

What the Research Says:

- Patients with **early** follow-up are less likely to drop out and more likely to improve (Bauer, 2011)
- Patients who have a second contact in less than a week are more likely to take their medications

Adjusting to End of Treatment

- Discuss treatment timeline and structure from the beginning
- Use PHQ-9 graph to help patients see progress
- Work with patient to find other sources of support
- Encourage the ongoing use of strategies for self-management
- Give specific end date when appropriate, e.g., 2 more session, spread sessions out more and more

Jasmines Progression

Jasmine has been responding to the medications and brief interventions.

Her PHQ is currently at 7, and we are preparing Jasmine for ongoing self-management. We've been reviewing with Jasmine key concepts of the relapse prevention plan.

What information would be helpful to Jasmine in a relapse prevention plan?

When would you introduce the relapse planning concepts?

Relapse Prevention Planning

The purpose of a relapse prevention plan is to help the patient understand his/her own personal warning signs.

These warning signs are specific to each person and can help the patient identify when depression may be starting to return so they can get help sooner – before the symptoms get bad.

The other purpose of a relapse prevention plan is to help remind the patient what has worked for him/her to feel better.

The relapse prevention plan should be filled out by the care manager and the patient together.

**Patient Education Toolkit: Sample Relapse Prevention Plan

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Use of the Relapse Prevention Plan

- Start working on the relapse prevention plan **at the beginning of care**
- Include it in the way you would record the way the patient most demonstrates
  - When not well
  - What is tried to help and works/doesn't work
  - What barriers there are to recovery
- Documenting and capturing pertinent information along the journey of remission/maximum improvement makes the work of creating the plan at the end less difficult
- For those that drop out of care, it is something they have been hearing all along

Care Coordination: Internal and External

- BHCM may perform co-visits with primary care providers and clinical staff as appropriate and requested
- BHCM will alert other clinicians and care providers to treatment plan changes, outcomes, and patient symptoms as appropriate
- BHCM will respond to patient crises as appropriate, which may include phone or clinic follow-up contacts or co-visits
- Care Coordination within the team. BHCM will document appropriately in EHR and systematic case review tool (may be one or two separate records, based on clinic technology). This includes sending notes to PCPs and other providers, and providing clear documentation with a summary of patient self-management plans, so the CoCM care team is aware of patient status and current care plan

Care Coordination with Community Based Services

- If patient is engaged in community-based services (e.g., psychotherapy), BHCM should consider getting patient's permission to obtain a Release of Information (ROI) to coordinate care appropriately.
- This might include coordination around medication management, sharing outcome measures, as well as diagnostics and treatment planning

Referrals

A successful referral:

- More than provision of a phone number/name to the patient
- Best to call ahead of the patient's appointment to set up expectations for the referral
- Discuss roles of the BHCM and the referring service
- Actively follow up on the referral ie treatment provided, recommendations, etc..
- Set up patient expectations on payment/cost/need to verify insurance coverage (benefits)
- Consider, if helpful, completing the call to the patient’s insurance with the patient on a conference call

Preparing for Case Closure

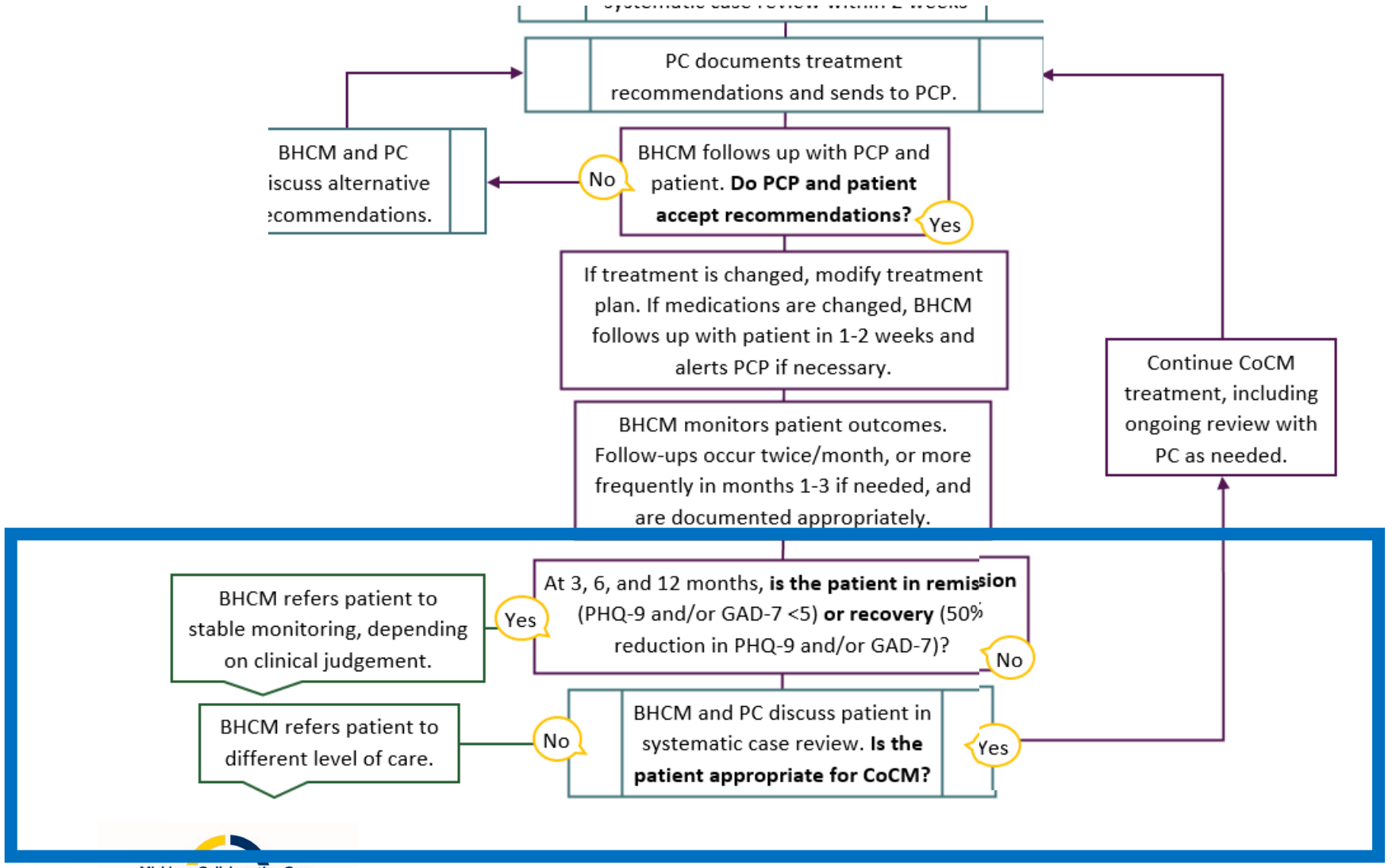
Jasmine has been managing independently for the last 2 months, she shows abilities to problem-solve, has been participating social activities, is comfortable with her medications and has overall confidence and satisfaction.

Her PHQ is now at a 3, indicating remission with the depression. The care team has a population health monitoring process for tracking depression and the provider agrees she is ready to return to usual care.

We will review the relapse prevention plan one more time with Jasmine and plan to proceed with discharge from BHCM for CoCare.

The team will be notified if this goes as planned.

Patient Status and Reason for Case Closure



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Monitoring and Managing Referrals

Transition to Community Resources:

1. Patient not getting better
2. Conditions requiring special expertise
3. Conditions requiring longer-term care
4. Need for recovery-based services (people with serious and persistent mental illness)
5. Patient request

Awareness of Community Resources

- Specialist Care
- SUD treatment
- Psychotherapy
- Community Mental Health (CMH)
- Other resources

Monitoring CoCM

- Track treatment (Treat-to-Target or need for Treatment Intensification)
- Follow-up contacts and delivering treatment plan
- Adjust treatment as needed
- Assess patient's improvement, as defined by treatment goals and program goals:
    - Adjust treatment accordingly
- Conclude treatment – when appropriate or if patient requests/drops out
- Relapse Prevention Planning Review or transition to community resources

Questions

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